

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155471		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/25/2012	
NAME OF PROVIDER OR SUPPLIER FOUR SEASONS RETIREMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1901 TAYLOR RD COLUMBUS, IN 47203			
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00115931.</p> <p>Complaint IN00115931 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey Dates: September 18, 19, 20, 21, 24 and 25, 2012</p> <p>Facility number: 000543 Provider number: 155471 AIM number: NA</p> <p>Survey Team: Cheryl Fielden RN TC Diana Sidell RN Jill Ross RN Gloria Reisert MSW September 20, 24, and 25, 2012</p> <p>Census Bed Type: SNF: 10 Residential: 96 NCC: 46 Total: 152</p> <p>Census Payor Type: Medicare: 10 Other: 142 Total: 152</p>			F0000	<p>Plan of Correction for F0000. Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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	<p>Sample: Residential: 7 NCC: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/01/12 by Suzanne Williams, RN</p>						

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F0223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure each resident was free from abuse, in that Resident #180 was verbally abused. This affected 1 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Record review on 9/20/12 at 5:00 p.m., for Resident #180 indicated diagnoses which included, but were not limited to, dementia, hypertension, depression and cognitive impairment.</p> <p>Review of documentation of an abuse allegation involving Resident #180, provided by Medical Records staff on 9/21/12 at 2:20 p.m., indicated there was an incident of verbal abuse. While sitting at the assisted dining room table, CNA #1 heard an Agency CNA (the facility had a contract with a nursing agency to provide help when needed) say to Resident #180,</p>			F0223	<p>Plan of Correction for F223. Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. Date the alleged abuse occurred: 7/21/2012. This tag results from a self-reported incident. Four Seasons reported this incident to ISDH, as required by our policies, in July, 2012. Four Seasons staff investigated the incident and took corrective actions in July and August, prior to the September survey. Tag from state is dated 9/21/2012. Corrective actions taken. Prior to this survey, facility</p>		10/25/2012

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	<p>"you're a grouchy, mean b-----." CNA #1 responded, "we don't talk to our residents that way. That is not appropriate!" The incident happened during lunch on 7/21/12 at 1:20 p.m., and CNA #1 did not report it to her nurse until the next morning at 6:00 a.m. Resident #180 was interviewed the day of the report, and did not remember anything about the incident.</p> <p>Interview with the Director of Nursing on 9/20/12 at 4:00 p.m., indicated CNA #1 was retrained on abuse and the importance of reporting it immediately.</p> <p>A policy titled, "Abuse, Investigation of/Protection of Resident" was received on 9/20/12 at 4:10 p.m. from the DON (Director of Nursing). This policy indicated, "...It shall be the policy of Four Seasons that upon the allegation or identification of abuse, neglect or misappropriation of resident property, Four Seasons shall immediately undertake an investigation of the allegation or event. It shall be the policy of Four Seasons to assure the safety of the resident involved during and after any such allegation...Allegation of abuse immediately reported to the DON and the Administrator for</p>		<p>management took steps to ensure that the Agency CNA involved in this incident will not work in Four Seasons facility in the future. The Agency that employed the CNA in question has been called and the incident has been reported to them. Prior to sending someone to work at our facility, the Agency must provide evidence that such Agency staff have been educated on Abuse, and that they meet the same educational criteria that Four Seasons staff are required to meet. The Agency CNA was called to come in and give a written statement as to what took place, which she did. In her written statement, she denied this incident ever took place. The employee that failed to report the abuse immediately was counseled, suspended for two days without pay, and was assigned an in-service. All Four Seasons employees receive abuse training annually (and PRN) at this time. After this incident, all current Four Seasons staff members were re-educated regarding abuse and reporting of abuse. The resident that was affected is a dementia patient and did not remember the incident taking place. No negative psycho social outcomes were noted resulting from this incident. All other residents who had been in the care of the Agency CNA were interviewed, and did not report any episodes of abuse during her</p>				

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	<p>investigation...Four Seasons will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals...It shall be the policy of Four Seasons to assure that all residents of this facility are free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion."</p> <p>3.1-27(b)</p>				<p>care. Measures and systemic changes to prevent recurrence. Four Seasons has always taken a proactive stance against resident abuse and will not tolerate such behavior by any individuals or groups, including employees, volunteers, family members, other residents, consultants, contractors, vendor personnel and/or visitors. If at all possible, we will not use agency personnel in the future. All Four Seasons staff know that if they abuse our residents in any way, they will be suspended immediately pending investigation. If at any time one of our staff members witnesses abuse in any form, they know to immediately remove the resident from where/whom the abuse is coming. In this incident, the resident was removed immediately from the dining table. All Four Seasons staff know to report abuse events immediately to their superiors. All alleged violations of the Four Seasons abuse policy are thoroughly investigated, and every attempt is made to prevent any future episodes. The results of all investigations are reported to the Executive Director immediately, and all other officials in accordance with regulations and laws. All violations are reported to the ISDH, as we did in this instance. Monitoring corrective actions to prevent recurrence. An "Action Plan" was developed to monitor corrective</p>		

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				<p>actions and education (see attachment "F223 action plan and analysis"), which were written and completed within two weeks. All Four Seasons staff were scheduled to be re-educated within 14 days, and this re-education was completed by that due date. The affected resident was monitored for 48 hours, to see if there was any residual effect from the incident; there was none. A mini "root cause analysis" was completed in order to brainstorm what we had done (see attachment "F223 action plan and analysis"), and to see if anything could have been done differently/better. The mini root cause analysis suggested that we did everything correctly, other than the Four Seasons CNA who did not report the issue immediately as required. Systemic changes identified in this Plan of Correction were completed originally by August 4, and for the purposes of this plan of correction, have been completed by October 25, 2012.</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F0225	Plan of Correction for F225.		10/25/2012		

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	<p>interview, the facility failed to ensure an allegation of abuse was reported immediately, in that Resident #180 was verbally abused, and CNA #1, who witnessed the abuse, did not report the incident until the next morning. This affected 1 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Record review on 9/20/12 at 5:00 p.m., for Resident #180 indicated diagnoses which included, but were not limited to, dementia, hypertension, depression and cognitive impairment.</p> <p>Review of documentation of an abuse allegation involving Resident #180, provided by Medical Records staff on 9/21/12 at 2:20 p.m., indicated there was an incident of verbal abuse. While sitting at the assisted dining room table, CNA #1 heard an Agency CNA (the facility had a contract with a nursing agency to provide help when needed) say to Resident #180, "you're a grouchy, mean b-----." CNA #1 responded, "we don't talk to our residents that way. That is not appropriate!" The incident happened during lunch on 7/21/12 at 1:20 p.m., and CNA #1 did not report it to her nurse until the next morning at 6:00</p>				<p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. Corrective actions taken. Regarding the Four Seasons CNA that witnessed the abuse event in July, 2012, and did not report it immediately as required – she stated that she went to the nurse's station immediately and attempted to talk to her nurse, but saw that change of shift report was occurring, and didn't want to interrupt, so she went home. During the night, she stated, she realized she should have told someone, so the next morning she came in early and told her nurse. Upon being told about the alleged abuse, the staff nurse re-educated the CNA regarding reporting any incident immediately to her nurse. The nurse then reported the abuse event immediately to the Executive Director and the Director of Nursing. An</p>		

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	<p>a.m. Resident #180 was interviewed the day of the report, and did not remember anything about the incident.</p> <p>Interview with the Director of Nursing on 9/20/12 at 4:00 p.m., indicated CNA #1 was retrained on abuse and the importance of reporting it immediately.</p> <p>A policy titled, "Abuse, Investigation of/Protection of Resident" was received on 9/20/12 at 4:10 p.m. from the DON (Director of Nursing). This policy indicated, "...It shall be the policy of Four Seasons that upon the allegation or identification of abuse, neglect or misappropriation of resident property, Four Seasons shall immediately undertake an investigation of the allegation or event. It shall be the policy of Four Seasons to assure the safety of the resident involved during and after any such allegation...Allegation of abuse immediately reported to the DON and the Administrator for investigation...Four Seasons will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal</p>			<p>investigation was immediately started and was completed. As part of the investigation, all individuals involved were questioned, along with all residents in the assisted dining room where the incident took place. This Four Seasons CNA was given a written counseling and was suspended without pay for two days for not reporting the incident immediately as required. She was also assigned a Silver Chair education assignment to complete within a week. She did complete the education on time. All Four Season Staff were re-educated regarding how to prevent and how to observe for the signs of all types of abuse. In addition, all Four Seasons staff were re-educated on reporting alleged abuse immediately. Review was also given as to what staff would need to do in case they observe abuse. They were reminded that the first step is to remove the resident from the incident or situation right away; and reporting comes immediately after. All of this re-education was done within the 14 days following the abuse event. Measures and systemic changes to prevent recurrence. The following information is given to, and acknowledgments are signed by, Agency personnel prior to them working at Four Seasons: information on Residents' Rights, Abuse, HIPPA and PHI, Infection Control, Hand Washing, Disaster</p>			

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	<p>guardians, sponsors, friends or other individuals...It shall be the policy of Four Seasons to assure that all residents of this facility are free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion."</p> <p>3.1-28(c)</p>			<p>Preparation, and General Orientation Information. To prevent further problems, we will also provide our own education of these same requirements prior to anyone providing care to our residents, whether it is our employee or contracted staff from an Agency. All new employees of Four Seasons automatically receive this education. Monitoring corrective actions to prevent recurrence. All staff education associated with this Plan of Correction will be monitored by our In-Service Coordinator, and reports will be provided at our quarterly QAA meetings showing that we are compliant. This report will be added to the quarterly QAA agenda. All Four Seasons staff will continue to be educated annually and prn on Abuse and the Elder Justice Act, as they are currently, and have been in the past (please see attachments "F225 abuse policy," and F225 elder justice documents"). Systemic changes identified in this Plan of Correction were completed originally by August 4, and for the purposes of this plan of correction, have been completed by October 25, 2012.</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their policy and procedure for the prevention of abuse and ensure an allegation of abuse was reported immediately, in that Resident #180 was verbally abused, and CNA #1, who witnessed the abuse, did not report the incident until the next morning. This affected 1 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Record review on 9/20/12 at 5:00 p.m., for Resident #180 indicated diagnoses which included, but were not limited to, dementia, hypertension, depression and cognitive impairment.</p> <p>Review of documentation of an abuse allegation involving Resident #180, provided by Medical Records staff on 9/21/12 at 2:20 p.m., indicated there was an incident of verbal abuse. While sitting at the assisted dining room table, CNA #1 heard an Agency</p>		F0226	<p>Plan of Correction for F226.</p> <p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. Corrective actions taken. Four Seasons has a long documented history of education and training for staff on policies involving abuse, neglect, reporting, and the Elder Justice Act. Four Seasons implemented an updated version of our Policy; 'Abuse, Investigation of/Protection of Resident' in October of 2011. At that time all staff were re-educated on abuse and reporting abuse. At the November 2011 staff meeting, reporting abuse was again discussed and emphasis was put</p>		10/25/2012	

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	<p>CNA (the facility had a contract with a nursing agency to provide help when needed) say to Resident #180, "you're a grouchy, mean b-----." CNA #1 responded, "we don't talk to our residents that way. That is not appropriate!" The incident happened during lunch on 7/21/12 at 1:20 p.m., and CNA #1 did not report it to her nurse until the next morning at 6:00 a.m. Resident #180 was interviewed the day of the report, and did not remember anything about the incident.</p> <p>Interview with the Director of Nursing on 9/20/12 at 4:00 p.m., indicated CNA #1 was retrained on abuse and the importance of reporting it immediately.</p> <p>A policy titled, "Abuse, Investigation of/Protection of Resident" was received on 9/20/12 at 4:10 p.m. from the DON (Director of Nursing). This policy indicated, "...It shall be the policy of Four Seasons that upon the allegation or identification of abuse, neglect or misappropriation of resident property, Four Seasons shall immediately undertake an investigation of the allegation or event. It shall be the policy of Four Seasons to assure the safety of the resident involved during and after any</p>		<p>on reporting any abuse immediately to the nurse, who in turn would notify the Executive Director and Director of Nursing, immediately. We have signed signatures that everyone received this education at the staff meeting. Also in October 2011, information was put on the "required information" wall regarding The Elder Justice Act and reporting abuse, and, the same information was placed in the copy room along with the Policy and Procedure book. Throughout the following months, staff continued to discuss abuse policies and the importance of reporting abuse immediately. In May 2012, abuse was again discussed at the monthly staff meeting and all staff members were given written information to read and sign and turn in to the In-Service Coordinator. Following this incident, in July, another copy of the Abuse policy and the Justice Elder Act was placed in the CNA assignment book. The Four Seasons CNA involved had been thoroughly educated and was aware of what the procedure was when there was an abuse situation. Four Seasons staff are fully aware at this time of their role in observing and reporting abuse immediately. If an alleged abuse situation happens, and our staff do not respond correctly, they will immediately be placed on suspension until our investigation is done and their</p>				

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	<p>such allegation...Allegation of abuse immediately reported to the DON and the Administrator for investigation...Four Seasons will not permit residents to be subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals...It shall be the policy of Four Seasons to assure that all residents of this facility are free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion."</p> <p>3.1-28(a)</p>			<p>return to work at Four Seasons will be based on the outcome of the investigation. On August 7, 2012, an additional in-service training ws conducted for staff (see attachment "F226 training document"). Measures and systemic changes to prevent recurrence. If in the future should we need to hire agency personnel, our In-Service Coordinator will personally re-educate the agency personnel on our policies as in the past, placing emphasis on abuse, prior to them working with our residents. The Director of Nursing will also educate the agency personnel and new hires as to how we expect our residents to be respected, and that we will have zero tolerance for anything less. Monitoring corrective actions to prevent recurrence. All in-services will be monitored on a monthly basis by our In-Service Coordinator, and will be reported upon at our quarterly QAA meetings on a continuing basis. Systemic changes identified in this Plan of Correction were completed originally by August 7, and for the purposes of this plan of correction, have been completed by October 25, 2012.</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food under sanitary conditions, in that hairnets and gloves were not worn properly, items in the refrigerators were outdated, and pans stacked as clean were dirty and wet. This was during 2 of 2 observations in the kitchens. This had the potential to affect all 152 residents in the facility.</p> <p>Findings include:</p> <p>Kitchen observation on 9/18/12 at 8:43 a.m., found there to be salad mix on the deli bar dated 9/17/12, buns with no date, 2 loaves of bread not sealed and not dated, and 13 cups of drinks with no lids or dates.</p> <p>During another observation on 9/18/12 at 11:15 a.m., the Dietary Supervisor had her bangs hanging out of her hairnet, and Dietary Aide #1 had her hair up in a bun with a hairnet only covering the bun with</p>			F0371	<p>Plan of Correction for F371. Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. Corrective actions have been planned and undertaken in the following categories. These issues have been and will be covered in dining services meetings on October 6 th and 13 th (see attachment F371B). Hairnets. The Hairnets Policy has been rewritten to include the following: That hair must be covered along the hair line; there should be no bangs or long hair not restrained. Use of head bands are allowed if hairnet</p>		10/25/2012

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	<p>long strands of hair around her face. Cook #2 used gloves to get food ready to put in the microwave, touched covers for the deli cabinet and went back to serving food. No glove changing occurred and no hand washing was done during this time.</p> <p>During dining room observation on 9/18/12 at 12:00 p.m., Dietary Aide #1 cleaned off a table after a resident had eaten, and threw the clothing protector in the kitchen on the floor.</p> <p>During observation of the residential kitchen (where the food is cooked and sent over to the skilled side) on 9/18/12 at 1:20 p.m., with the Dietary Manager, there was a box of saltine crackers sitting on the floor in the wait station stock room. In the dry storage room there was a box of cream of wheat with an expiration date of 6/19/12 and a box of rice with an expiration date of 8/30/12. The #1 refrigerator had gravy with a use by date of 9/15/12. There were three pans stacked, ready to be used that were wet. There was a long cookie sheet that was dirty.</p> <p>Interview with the Dietary Manager on 9/18/12 at 1:40 p.m., indicated he would re-educate his staff and get these things corrected immediately.</p>		<p>covers up to the hairline. Production staff is allowed to wear chef hats or ball caps to cover hair (please see attachment F371A). In-service training has been scheduled for October 6th and October 13th with copies of the re-written policy distributed to all employees and managers.</p> <p>Disposable Gloves. The existing Policy for proper usage of disposable gloves (see attachment F371C) will be handed out to all staff at mandatory department meetings scheduled for October 6th and October 13th. Management will demonstrate proper technique and changing of gloves, including hand washing.</p> <p>Dates and Labeling. It will be the responsibility of the manager-on-duty to check labels & dates to ensure compliance with Morrison policy on dates and labeling each night (please see attachment F371D). This process has been put in place effective October 6, 2012. Policy for proper label and dating will be handed out to all staff at mandatory department meetings scheduled for October 6th and October 13th. Label & dating will be addressed at all 3 meals, show time (or stand up), and daily production meetings in both kitchens.</p> <p>Four employees have received disciplinary action for improper label and dating. Staff have</p>				

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	<p>A policy titled, "Sanitation and infection control - Disposable Glove Use" was received from the Dietary Manager on 9/19/12 at 10:25 a.m. This policy stated when gloves are to be worn and then moves on to "Procedures:..Disposable gloves must be changed when dirty or ripped and when moving from one task to another..."</p> <p>Another policy - titled, Uniform Dress Code" was received from the Dietary Manager on 9/19/12 at 10:30 a.m. This policy stated, "...Wear the approved hair restraint when on duty."</p> <p>A policy titled, "Food and Supply Storage Procedures" was received from the Dietary Manager on 9/19/12 at 10:30 a.m. This policy stated, "...Procedures:... The "use-by" date is the last date that a food can be consumed...Store dry and staple items at least____" above the floor...Remove from storage any items for which the expiration date has expired...Store linens covered in a clean, dry location to prevent contamination...Refrigerator Storage...Label and date containers."</p> <p>3.1-21(i)(3) 5-5.1(k)</p>				<p>developed and implemented checklists to monitor all freezers, refrigerators and dry storage for compliance with labels and dates policies. This checklist will be initialed daily. This will be added to staff's job routine, and addressed at a meeting scheduled for 10/10/12. Washing and Drying. The Policy for proper pot & pan washing and drying (see attachment F371E) will be handed out to all staff at mandatory department meetings scheduled for October 6th and October 13th. Proper washing and drying will be addressed at all 3 meals, show time, and daily production meetings in both kitchens on those dates. Beginning October 6 the clothing protector bin has been and is to be used at all meals. Measures and systemic changes to prevent recurrence. Hairnet coverage will be monitored at all 3 meals, show time (or stand up), and production meetings, daily, in both kitchens by the manager-on-duty. Disposable glove usage will be monitored by the manager on duty. Disposable Glove Policy will be reiterated daily in all shifts for both kitchens. Disposable glove usage will be monitored by manager on duty. Policy will be reiterated daily in all shifts for both kitchens. Manager on duty will monitor dates and labeling activities daily (please see attachment F371F). Managers</p>		

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					<p>will ensure the clothing protector bin will be utilized at all 3 meals. Monitoring corrective actions to prevent recurrence. Disciplinary action for non compliance with hairnet policies will be enforced. Disciplinary action for non compliance with disposable glove policies will be enforced. Disciplinary action for non compliance with dates and labeling policies will be enforced. Systemic changes in this Plan of Correction will be completed by October 25, 2012.</p>		

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to do a</p>			F0441	Plan of Correction for F441 Improper Mantoux Skin Test		10/25/2012

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	<p>second step Tuberculin test (PPD) 14 days after the first step was done for an employee. This affected 1 (Cook #1) of 10 employee files reviewed for PPD testing.</p> <p>Findings include:</p> <p>Review of employee files on 9/21/12 at 8:00 a.m., indicated Cook #1 had started to work on 7/27/12. He received his first step PPD on 7/26/12 and it was read on 7/28/12. It also indicated that the second step PPD was given on 7/28/12 in the other arm. There was another PPD done on 9/14/12.</p> <p>During an interview with the Inservice Director on 9/21/12 at 12:05 p.m., she indicated Cook #1 was given his first PPD on 7/26/12 and it was read on 7/28/12. The second step PPD was given on 7/28/12 in the other arm. "This was done due to the reaction of 4.2 mm (millimeters). They thought they were just redoing the first step but the actual second step was not done until 9/14/12."</p> <p>Review of the policy titled, "Tuberculosis Testing," received 9/21/12 at 11:00 a.m., from the Inservice Director, indicated, "Policy: ...3. Each employee must have had a</p>				<p>Corrective actions taken. An internal audit of employee files has been completed to make sure that all employee Mantoux skin tests and the subsequent readings have been done correctly and within the proper time frames. No further errors were found as a result of this audit. Four Seasons Tuberculosis Testing policy has been updated to reflect changes made regarding the 2012 F441 tag, effective October 2012 (please see attachment F441A policy). Measures and systemic changes to prevent recurrence. In the future, as is the current policy and practice, new Four Seasons employees will receive two-step Mantoux (PPD) skin tests and readings within 30 days prior to beginning of employment. If not, a first test will be given and read prior to employment and a second test will be given and read 10 to 14 days later. Annually, each employee will receive a Mantoux skin test (PPD). Each employee with an induration of 5 to 9 mm on the first test will be retested at that time, and a second test will be done 10 to 14 days later. Each employee who has a positive Mantoux (PPD) will receive a chest x-ray. Each employee who has a positive Mantoux (PPD) will have an Annual Tuberculosis Assessment, both immediately, and annually thereafter.</p>		

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R0000	<p>Mantoux (PPD) within 30 days prior to beginning employment. If not, one will be given prior to employment and a second step given 10 to 14 days later...5. Each resident or employee who has a positive Mantoux (PPD) will receive a chest x-ray...Always read test in mm: 1. Induration (wheal) less than 5 mm - not significant. 2. Induration (wheal) between 5 mm and 9 mm inclusive - Possibly Significant (Not reported as significant, repeat test) 3. Induration (wheal) 10 mm or more - Significant."</p> <p>3.1-18(k) 3.1-14(t)(1)</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2-5.</p>			R0000	<p>The Staff Coordinator will ensure that no one starts orientation without their pre-employment Mantoux skin test. Employee files will be audited by the Director of Human Resources to ensure pre-employment requirements are met. Monitoring corrective actions to prevent recurrence. The Director of Human Resources will audit new hire files and their results will be reviewed at the quarterly QAA meetings until 3 consecutive meetings show continued compliance (see attachment F441B checklist). Thereafter, Compliance with all pre-employment Mantoux testing will be ensured through routine auditing by the Staff Coordinator and the Director of Human Resources. Systemic changes in this Plan of Correction will be completed by October 25, 2012</p>		

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R0055	<p>410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.</p> <p>Based on interview and record review, the facility failed to ensure a resident had privacy in that staff entered her room without knocking for 1 of 3 residents interviewed for privacy. (Resident #205)</p> <p>Findings include:</p> <p>During an interview on 9/25/12 at 2:00 p.m., Resident #205 indicated she was not able to have privacy when she wanted. She indicated that on two different times, two different staff walked in without knocking. The first time the staff came into her room, she was in the bedroom and the person used their key to enter, didn't knock, and walked into her bedroom. Resident #205 indicated that when she saw her, she turned around and left without speaking. The second time, they just walked in and started talking to her about placing a dot on her door that would indicate her code status. The two staff used their key to enter and didn't knock. Resident</p>		R0055	<p>Plan of Correction for R055. Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through paper review. On August 17, 2012, Four Seasons staff met with this resident in her apartment at her request in regards to a concern she wished to raise. The concern was that on August 16, 2012, she felt an aide and a laboratory technician had knocked on her door, and did not give her time to answer before they used a key to enter. The resident stated that she takes her hearing aids out while she is in her apartment for</p>		10/25/2012	

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	<p>#205 indicated it bothered her that she doesn't have privacy and this is her apartment.</p> <p>On 9/25/12 at 5:00 p.m., the Director of Nursing Services provided an "Orientation for all new employees" as their policy for knocking on resident's doors before entering their room. The document indicated: "General orientation information...2. We always knock on the resident's door before entering the room even if the resident is hard of hearing or deaf...."</p> <p>During an interview on 9/25/12 at 5:00 p.m., the Director of Health services indicated they haven't had any residents complain of staff not knocking before entering a resident's room.</p>			<p>comfort reasons and will need more time than most to respond to a knock. She stated that hearing the knock was also a problem at her residence out in the community, and that she had labeled her door "Please give me time to answer the door." Staff asked this resident if she would like Four Seasons to do the same and she said yes. The door was labeled immediately – "Please give me time to answer the door following your knock".</p> <p>Corrective actions taken. Nursing staff that work in the Residential Center have been interviewed regarding entering Resident # 205's apartment without knocking. They state that Resident # 205 has hearing aids, but frequently chooses not wear them. Nursing staff all state that they do knock on the door, but when she has her hearing aids out, she does not hear them. After knocking more than once, they will use the key to open the door and see if she is OK. Because she has not heard the knock, she believes that they have not knocked.</p> <p>A new policy has been written entitled 'Apartment Visits' (please see attachment R055, page 1). This policy states that "It is the policy of this facility that residents have the right to be treated as individuals with consideration and respect for their privacy. The facility will ensure that a resident has privacy in that all staff will</p>			

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				<p>knock and wait for a response before entering.”</p> <p>Procedure: 1) all staff will knock on resident's door; 2) staff will wait for resident to respond (opening door or saying "come in"); 3) if there is no response, staff will open door slightly and identify self to resident and ask to come in, and wait again for response.</p> <p>Measures and systemic changes to prevent recurrence. This policy has been activated and will be given to all nursing staff to read and sign as an acknowledgement by October 10th, 2012 (see attachment R055, page 2). Residents will be notified immediately that a new policy has been written, and they will know that they will need to respond as to whether staff may enter upon hearing a knock. Residents will be encouraged to let the Nursing Manager or Director of Nursing know if this policy is not being followed. If this policy is violated by nursing staff, the responsible person will be issued a written counseling per our Counseling policy.</p> <p>All nursing staff working on residential will be educated to the new policy entitled 'Apartment Visits' by October 10, 2012. All nursing staff working on residential will also be informed that our counseling policy will be enforced should they not adhere to the policy.</p> <p>Monitoring corrective actions to</p>			

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				prevent recurrence. Any further violations and discipline will also be reported at our quarterly QAA meeting by the Residential Nursing Manager. Systemic changes in this Plan of Correction will be completed by October 25, 2012			

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R0116	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>Based on record review and interview, the facility failed to check references before hiring 3 dietary staff. This affected 3 out of 10 employees reviewed for references in a sample of 10. (Dietary Supervisor, Cook #1 and Dietary Aide #2)</p> <p>Findings include:</p> <p>Review of employee files on 9/21/12 at 8:00 a.m., indicated three dietary staff without reference checks prior to employment. The staff were: Dietary Supervisor, Cook #1 and Dietary Aide #2.</p> <p>On 9/20/12 at 3:25 p.m., in an interview with the Dietary Manager, he stated, "We don't do reference checks any more." "We don't have a policy for this."</p>	R0116	<p>Plan of Correction for R116. Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Four Seasons requests that compliance with Federal and State rules be determined through Corrective actions taken. References will be checked on any and all new hires for the contracted Dining Services, starting 9/25/12 (please see attachment R116 pre-employment policy). Reference checks will be documented in the application files. Measures and systemic changes to prevent recurrence. Reference checks will be performed and</p>		10/25/2012		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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				<p>documented in personnel files. The Food Service vendor's employment application files will be audited for compliance. The Dining Service Manager will work with the Four Seasons personnel coordinator in performing audits of personnel files. Monitoring corrective actions to prevent recurrence. Results of file audits will be reported in quarterly compliance meetings of the facility's QAA committee. Systemic changes in this Plan of Correction will be completed by October 25, 2012</p>			

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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure the clinical record was complete, in that a physician's order to self-administer medications was lacking in a resident's record. This deficient practice affected 1 of 3 residential residents reviewed for self-administration of medications in a residential sample of 7. (Resident #225)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #225 on 9/25/2012 at 2:49 p.m., indicated the resident was admitted on 8/26/2012 and had diagnoses which included, but were not limited to: asthma, arthritis, fibromyalgia, and status post breast cancer.</p> <p>Review of the "Assessment For Self-Administration Of Medications"</p>	R0349	<p>Plan of Correction for R349. Corrective actions taken in regards to resident #225's self-administration of medication. The resident's physician was called immediately and an order obtained for resident #225 to self-administer her medications. The order was written and notation was put on the Medication Administration Record that an order had been obtained. Measures and systemic changes to prevent recurrence. All charts will be audited to ensure that all residents that self-administer their medications have a written order from their primary physician stating that they can do so. Any charts that do not have the appropriate order will be corrected immediately. A new Admissions Paperwork Audit form has been updated and will be used to audit the charts. The new Admission Audit Policy has been corrected and updated also. These documents are attached in R349. Any charts that find an order for</p>	10/25/2012			

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	<p>completed by nursing on 8/28/2012. indicated the resident was capable of self-administering her own medications.</p> <p>The August and September 2012 Medication Administration Records (MARs) indicated the resident administered her own medications. Documentation was lacking of a physician order for the resident to do so.</p> <p>During an interview with LPN #5 on 9/25/2012 at 3:00 p.m., she indicated there was no order by the physician on the monthly physician order sheets or telephone order forms for the resident to give her own medications.</p>				<p>self administering medications missing will be audited to see what nurse did the admission and didn't obtain the order. The responsible nurse will receive a written counseling per our discipline policy. After all current charts are audited to make sure residents that self administer their own medications have a physician order stating that they can, new admission charts will be audited by Medical Records within 24 hours. Cited deficiencies will be given to the Nurse Manager to correct within 48 hours. The completed audit form will then be returned to the Medical Records Director. Monitoring corrective actions to prevent recurrence. The Medical Records Director will report on the audit at the Quarterly QAA meeting. Systemic changes in this Plan of Correction will be completed by October 25, 2012</p>		

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R0356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency files contained sufficient information (correct apartment number, clear identifiable pictures, physician name and/or phone numbers, hospital preference and emergency contact information) in the event of an emergency for 3 of 5 sampled residential records (Residential Residents #226, 170 and 225) and 31 of 93 supplemental residential records reviewed. (Residential Residents #234, 235, 167, 151, 164, 219, 150, 163, 162, 221, 237, 140, 165, 233, 138, 129, 149, 142, 147, 227, 190, 133, 194,</p>		R0356	<p>Plan of Correction for R 356.A current emergency information file shall be immediately accessible for each resident, in case of emergency. Several areas were not complete in the emergency file and were tagged due to the omissions. Out of 93 charts reviewed, 34 were found to have incomplete information. a) A review of emergency information files for the following residents concluded that identification pictures were dark, blurry and difficult to identify the resident in the event of an emergency; # 226, 170, 234, 235, 167, 151, 219, 163, 162, 221, 237, 140, 165, 233, 138, 129, 149, 142, 227, 194, 215, 211, 136, 209,</p>		10/25/2012	

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	<p>215, 211, 178, 171, 136, 209, 213, and 159)</p> <p>Findings included:</p> <p>Review of the Emergency Files on 9/25/2012 at 1:15 p.m., indicated the following:</p> <ol style="list-style-type: none"> 1. Resident #226 was admitted on 4/2/99 and had a picture that was blurry and difficult to identify the resident in the event of an emergency. 2. Resident #170 was admitted on 4/24/11 and had a picture that was blurry and difficult to identify the resident in the event of an emergency. 3. Resident #205 was admitted on 7/7/12. The Emergency Facesheet listed the wrong room number for the resident. 4. Resident #234 was admitted on 12/14/10 and had a picture that was blurry and difficult to identify the resident in the event of an emergency as it was also taken at a distance from the resident. 5. Resident #235 was admitted on 12/14/10 and had a picture that was 				<p>213, and 159. A review of emergency information files for the following residents found that the Emergency Facesheet listed the wrong apartment number for the resident: # 205, 164, 150, 190, b) Resident # 147's Emergency Facesheet was missing the physician's name and phone number. c) Resident # 178's Emergency Facesheet listed the resident herself as the Emergency contact person. d) Resident # 171's Emergency Facesheet was missing the physician's phone number and hospital preference. e) Resident # 133 Emergency Facesheet was missing the phone number of the emergency contact person. Corrective actions taken. Regarding (a.) Nursing has taken new pictures of the residents that had blurry and/or unidentifiable pictures. The Billing Manager has uploaded the pictures onto the face sheets. The new face sheets have been placed in the Emergency Files. Regarding (b), (c), (d), and (e), all corrections were made on the Emergency Facesheet and placed in the Emergency Information Files. The Resident Emergency Profile Procedure and Policy has been updated to reflect changes that have been made. All current charts and Emergency Information Files have been audited for missing information. All corrective measures have been completed. All new charts</p>		

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	<p>blurry and difficult to identify the resident in the event of an emergency as it was also taken at a distance from the resident.</p> <p>6. Resident #167 was admitted on 3/22/02 and had a picture that was very dark and difficult to identify the resident.</p> <p>7. Resident #151 was admitted on 4/14/11 and had a picture that was very dark and difficult to identify the resident.</p> <p>8. Resident #164 was admitted on 10/3/05. The Emergency Facesheet listed the wrong apartment number for the resident.</p> <p>9. Resident #219 was admitted on 3/1/07 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>10. Resident #150 was admitted on 6/12/12. The Emergency Facesheet listed the wrong apartment number for the resident.</p> <p>11. Resident #163 was admitted on 9/15/11 and had a picture that was blurry and difficult to identify the resident in the event of an</p>				<p>will be audited by the Residential Nurse Manager within 48 hours of residents being admitted. Any omissions, if found, will immediately be corrected. Omissions and corrections will be reported to the Medical Records Director and Billing Manager. Monitoring corrective actions to prevent recurrence. Residential charts and Emergency Information Files will be monitored on a quarterly basis. Audits will be performed by residential staff and the Residential Nurse Manager will report the results at our Quarterly QAA meetings. A copy of both the revised policy and an audit form are attached in R356 emergency files. All systemic changes will be completed by October 25, 2012.</p>		

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	<p>emergency; name and phone number of physician and hospital preference were missing.</p> <p>12. Resident #162 was admitted on 9/15/11 and had a picture that was blurry and difficult to identify the resident in the event of an emergency and had no Apartment number listed on the Emergency Facesheet.</p> <p>13. Resident #221 was admitted on 10/25/06 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>14. Resident #237 was admitted on 5/1/06 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>15. Resident #140 was admitted on 12/19/11 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>16. Resident #165 was admitted on 9/9/11 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p>						

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	<p>17. Resident #233 was admitted on 3/9/09 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>18. Resident #138 was admitted on 6/30/12 and had a picture that was dark and difficult to identify the resident in the event of an emergency.</p> <p>19. Resident #129 was admitted on 8/12/11 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>20. Resident #149 was admitted on 1/20/11 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>21. Resident #142 was admitted on 12/16/11 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>22. Resident #147 was admitted on 7/30/10. A physician's name and phone number was missing.</p> <p>23. Resident #227 was admitted on</p>						

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	<p>7/30/06 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>24. Resident #190 was admitted on 6/18/10. The Emergency Facesheet listed the wrong apartment number for the resident.</p> <p>25. Resident #133 was admitted on 5/5/01. The phone number of the emergency contact person was missing.</p> <p>26. Resident #194 was admitted on 5/26/07 and had a picture that was dark and difficult to identify the resident in the event of an emergency.</p> <p>27. Resident #215 was admitted on 2/28/08 and had a picture that was blurry and difficult to identify the resident in the event of an emergency as it was also taken at a distance from the resident.</p> <p>28. Resident #211 was admitted on 5/15/12 and had a picture that was dark and difficult to identify the resident in the event of an emergency.</p> <p>29. Resident #178 was admitted on</p>						

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	<p>6/22/93. The Emergency Face sheet listed the resident herself as the emergency contact person.</p> <p>30. Resident #171 was admitted on 6/18/11. The physician's phone number and hospital preference was missing.</p> <p>31. Resident #136 was admitted on 12/1/09 and had a picture that was dark and difficult to identify the resident in the event of an emergency.</p> <p>32. Resident # 209 was admitted on 7/10/07 and had a picture that was dark and difficult to identify the resident in the event of an emergency.</p> <p>33. Resident #213 was admitted on 9/30/06 and had a picture that was blurry and difficult to identify the resident in the event of an emergency.</p> <p>34. Resident #159 was admitted on 5/28/05 and had a picture that was dark and difficult to identify the resident in the event of an emergency.</p> <p>During an interview with QMA #1 on 9/25/2012 at 2:10 p.m., she indicated</p>						

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	<p>that nursing would take the picture of the resident and then give the picture disk to the Billing Manager to upload the picture onto the face sheet. She also indicated the Billing Manager was also responsible for updating the face sheets when changes were made.</p> <p>During an interview with the Billing Manager on 9/25/2012 at 2:30 p.m., she indicated it was possible that the pictures in the emergency file were blurry because they were not the original facesheet, but a copy or a copy of a copy. She indicated it was not possible to lighten the print to make the picture clearer. She also indicated that she was going to print all new face sheets and let nursing review them for ones that needed an updated picture.</p> <p>During the interview with the Billings Manager, she also indicated all face sheets had been updated on 7/15/2009.</p>						